

# Fallon Medicare Plus™ Premier HMO

Jan. 1, 2025–Dec. 31, 2025

care.  
It's what we believe in.



# Welcome to Fallon Health.

Fallon Health is a not-for-profit health care services organization that has been improving health and inspiring hope for more than 45 years. As the first health plan in the country to offer a Medicare Advantage plan, we're committed to providing care and coverage that goes further. We build our products and benefits to make sure that you receive the care you need and deserve.

Massachusetts is our home, and our team is local. When you call us, you'll speak with someone who knows, and serves, this community. We believe that health care is personal and that you should be able to talk to a real person—not a computer. Because we want you to get the service you need, when you need it.

Please keep reading. We think you'll like the rich benefits you'll find on the pages ahead.



# Pay \$0. Get a lot!

With Fallon Medicare Plus Premier HMO, you'll get benefits that are designed to help you stay healthy and save money.



- Medical and prescription deductible
- Annual physical exam
- Preventive screenings
- Prescriptions (Tiers 1 and 6 drugs)
- Preventive dental
- Telehealth visits (PCP, behavioral health, and Teladoc®)
- 24/7 phone access to registered nurses
- Hi-tech imaging: MRIs, nuclear studies, and PET and CT scans
- X-rays, labs, and tests

Get **\$250 in your Benefit Bank**. The Benefit Bank card is preloaded with money that can be used for dental care, prescription eyewear, fitness/gym memberships, and prescription hearing aids.

Keep reading to learn more.

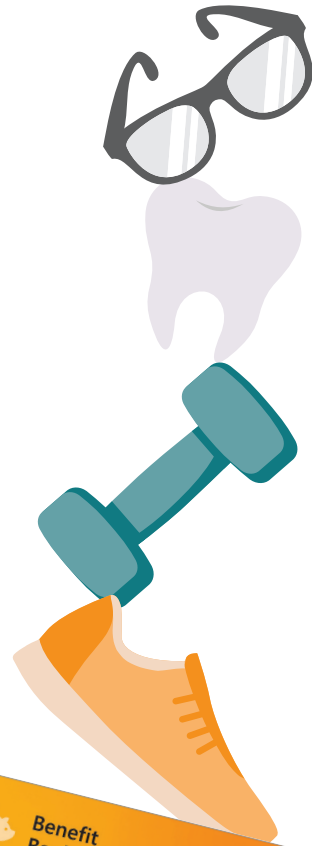
# The Benefit Bank

You'll get \$250 per year to pay for dental care, prescription eyewear, gym/fitness memberships, and prescription hearing aids—with the Benefit Bank.

Fallon Health preloads money onto your Benefit Bank card, and you choose how to use it. Pay a portion—or the full cost—of an eligible item, or buy a combination of items. It's your card, and you choose how to use it.

For example, if you need a filling and see a dentist in our network, you can use your Benefit Bank to cover your copay and have money left to pay for something else. If you see an out-of-network dentist, you can use your Benefit Bank to pay for the cost of the filling.

**We'll give you \$250! Spend it how you want!**



- \$250 to spend on
- dental care
  - prescription eyewear
  - fitness/gym memberships
  - prescription hearing aids



# Save money with these extras.

## Dental

You pay \$0 for routine preventive dental like cleanings, exams, and X-rays. Comprehensive dental care, like root canals, fillings, and crowns, are also covered—at network dentists—with a copay. Your Benefit Bank can be used to pay for copays and out-of-network dental services.

## Eyewear

\$150 toward eyewear, every year. You can also use your Benefit Bank toward additional—or out-of-network—eyewear costs.

## Hearing aids

Pay between \$695 and \$2,645 when you make purchases through Amplifon. Copays vary by hearing aid type and technology. You can use your Benefit Bank toward these copayments or on prescription hearing aids purchased from other providers.

## Teladoc®

24/7 access to treatment from board-certified doctors, by phone, mobile app, or video—with a \$0 copay.

## Care Connect

24/7 access to registered nurses by phone, with a \$0 copay. Nurses provide guidance on where to go for care and/or they can connect you with your doctor.



# Medical benefits

**Benefits that work for your needs and budget.**

| Benefits and copayments                                                    |                     |
|----------------------------------------------------------------------------|---------------------|
| Annual supplemental physical exam                                          | \$0                 |
| Primary care provider (PCP) office visits                                  | \$15                |
| Telehealth: PCP, behavioral health, and Teladoc                            | \$0                 |
| Specialty office visits, in person or via telehealth—except as noted above | \$25                |
| Preventive dental (cleanings, exams, and X-rays)                           | \$0                 |
| Routine eye exam                                                           | \$25                |
| Ambulance                                                                  | \$0                 |
| Inpatient hospital care—acute                                              | \$250 per admission |
| Diagnostic services<br>(Tests, procedures, X-rays, labs)                   | \$0                 |
| Hi-tech imaging<br>(CT, PET, and MRI scans and nuclear studies)            | \$0                 |
| Outpatient surgery                                                         | \$125               |
| Worldwide ER visits                                                        | \$75                |
| Urgent care<br>Inside/Outside the U.S.<br>and its territories              | \$15/\$75           |
| Part D prescription drug coverage                                          | Included            |

# Prescription drug coverage

|                           | Retail (30/60/90-day supply) | Mail order (30/60/90-day supply) |
|---------------------------|------------------------------|----------------------------------|
| <b>Tier 1<sup>1</sup></b> | \$0/\$0/\$0                  | \$0/\$0/\$0                      |
| <b>Tier 2</b>             | \$10/\$20/\$30               | \$10/\$20/\$20                   |
| <b>Tier 3</b>             | \$30/\$60/\$90               | \$30/\$60/\$60                   |
| <b>Tier 4</b>             | \$65/\$130/\$195             | \$65/\$130/\$162.50              |
| <b>Tier 5</b>             | \$65<br>(30-day supply only) | \$65<br>(30-day supply only)     |
| <b>Tier 6</b>             | \$0<br>(30-day supply only)  | \$0<br>(30-day supply only)      |

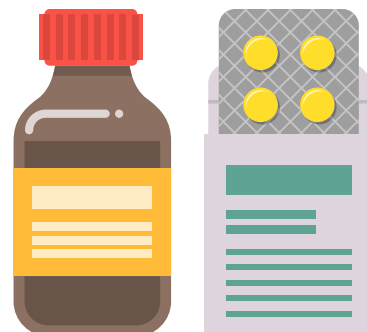
Your copays for insulin drugs purchased at a retail location are no more than: \$35 for a 30-day supply; \$70 for a 60-day supply; \$105 for a 90-day supply. Your copay for insulin drugs is no more than \$70 for a 90-day mail-order supply.

Our plan covers most Part D vaccines at no cost to you.

<sup>1</sup> Up to a 100-day supply for Tier 1 medications through mail order or at a retail location.

**Mail Order:** Pay \$0 for up to a 100-day supply of Tier 1 medications. Tiers 2 and 3 medications are available for up to a 90-day supply for the cost of a 60-day supply. Tiers 5 and 6 medications are limited to a 30-day supply.

For more information see the Summary of Benefits, which appears later in this booklet.



# Before you enroll

To make sure that you choose the plan that's right for you, it's important to ask yourself these 2 questions:

## 1. Are my doctors in the network?

You should always check to make sure you can continue to see your doctors before enrolling in a plan. If your doctors aren't in the plan you choose, you won't be able to see them and you'll have to choose new doctors for your care. Visit [fallonhealth.org/findphysician](https://fallonhealth.org/findphysician) to confirm that your doctors and other providers are in the plan that you choose. Our network includes top quality providers from across the state.

## 2. Are my prescription drugs covered?

You can view the list of Part D prescription drugs that are covered with our plans by visiting our website at [fallonhealth.org/medicare-formulary](https://fallonhealth.org/medicare-formulary). While you're there, you can also make sure that your pharmacy is in our network.

Prescription cost-sharing starts at \$0 for Tier 1 drugs at network retail and mail-order pharmacies. For Tiers 2 and 3 medications that are available in a long-term supply, you can use mail order to get up to 90 days' worth for the cost of a 60-day supply.

For more detailed prescription copayment information, please see the Summary of Benefits, which appears later in this booklet.



**Call us at  
1-866-231-3669 (TRS 711)**

# Let's get started!

We look forward to having you as a member. Before you submit any paperwork, please review the checklist below. Having this information will help us process your request faster.

## Did you tell us ...

- ☐ Your full legal name as it appears on your Medicare card
- ☐ Your date of birth
- ☐ Your telephone number
- ☐ Your home address
- ☐ Your Medicare information  
If needed, you may attach a photocopy of your Medicare card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board. If you don't have your Medicare information, call your local Social Security office to obtain proof of enrollment.
- ☐ Answers to the important questions on pages 1-2 of the enrollment form
- ☐ The name, contact information, and signature of the individual who helped you complete the form, if applicable.



Please be sure you complete all required fields and sign and date the enrollment form.

# Enrollment materials

In this section you'll find everything you need to enroll, including:

- Enrollment form
- Summary of Benefits
- Pre-enrollment checklist
- Medicare Star ratings

# Fallon Medicare Plus™ Premier

## Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a Fallon Health representative at 1-866-231-3669 (TRS 711), 8 a.m.–8 p.m., Monday–Friday (7 days a week, Oct. 1–March 31).

### Understanding the benefits

- ☐ The Evidence of Coverage (EOC) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [fallonhealth.org/medicare](https://fallonhealth.org/medicare) or call 1-866-231-3669 (TRS 711) to view or request a copy of the EOC.
- ☐ Review the Provider Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the Pharmacy Directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.
- ☐ Review the Formulary to make sure your drugs are covered.

### Understanding important rules

- ☐ Benefits, premiums, and/or copayments/coinsurance may change on January 1, 2026.
- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the Provider Directory).
- ☐ **Effect on current coverage.** If you are currently enrolled in a Medicare Advantage plan, your current Medicare Advantage healthcare coverage will end once your new Medicare Advantage coverage starts. If you have Tricare, your coverage may be affected once your new Medicare Advantage coverage starts. Please contact Tricare for more information. If you have a Medigap plan, once your Medicare Advantage coverage starts, you may want to drop your Medigap policy because you will be paying for coverage you cannot use.



# 2025 Fallon Medicare Plus™ Premier HMO Enrollment Form

## SECTION 1 – All fields on this page are required *(unless marked optional)*.

To enroll, please provide the following information:

|                                                                                                                                                                                    |                                                               |                                                                                                                        |                                   |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------|-----------------------------------|
| Company name:                                                                                                                                                                      |                                                               | Group number:                                                                                                          |                                   |
| Authorized signature:                                                                                                                                                              |                                                               | Requested effective date:                                                                                              |                                   |
| Last name:                                                                                                                                                                         |                                                               | First name:                                                                                                            | Middle initial: <i>(optional)</i> |
| Birth date: (MM/DD/YYYY)<br>____ / ____ / ____                                                                                                                                     | Sex: <input type="checkbox"/> M<br><input type="checkbox"/> F | Home phone number:<br>( ____ ____ ) ____ ____ - ____ ____ ____                                                         |                                   |
| Preferred written language: <i>(optional)</i>                                                                                                                                      |                                                               | Preferred spoken language: <i>(optional)</i>                                                                           |                                   |
| Mobile phone number: <i>(optional)</i><br>( ____ ____ ) ____ ____ - ____ ____ ____                                                                                                 |                                                               | Email address: <i>(optional)</i><br>_____                                                                              |                                   |
| <input type="checkbox"/> I authorize Fallon Health to send me text messages related to my plan benefits and services.                                                              |                                                               | <input type="checkbox"/> I authorize Fallon Health to send me email messages related to my plan benefits and services. |                                   |
| Permanent residence street address (Don't enter a PO Box. Note: For individuals experiencing homelessness, a PO Box may be considered your permanent residence address.):<br>_____ |                                                               |                                                                                                                        |                                   |
| City/town:                                                                                                                                                                         | State:                                                        | ZIP code:                                                                                                              | County: <i>(optional)</i>         |

Mailing address *(only if different from your permanent address)*:

Street address: \_\_\_\_\_

City/town: \_\_\_\_\_ State: \_\_\_\_\_ ZIP code: \_\_\_\_\_

Please provide your Medicare insurance information.

Please take out your red, white, and blue Medicare card to complete this section.

|                                                                                                                                                                                                                                                                                                   |                                                      |                 |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|-----------------|
| Fill out this information as it appears on your Medicare card.<br><b>OR</b><br>Attach a copy of your Medicare card or your letter from the Social Security Administration or the Railroad Retirement Board.<br><b>You must have Medicare Part A and Part B to join a Medicare Advantage plan.</b> | Name (as it appears on your Medicare card):<br>_____ |                 |
|                                                                                                                                                                                                                                                                                                   | Medicare number: _____                               |                 |
|                                                                                                                                                                                                                                                                                                   | Is entitled to:                                      | Effective date: |
|                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> Hospital (Part A)           | _____           |
|                                                                                                                                                                                                                                                                                                   | <input type="checkbox"/> Medical (Part B)            | _____           |

Please read and answer these important questions.

1. Are you the retiree? ☐ Yes ☐ No

If yes, retirement date (month/date/year): \_\_\_\_\_

If no, name of retiree: \_\_\_\_\_

Please read and answer these important questions (continued).

2. Are you covering a spouse or dependents under this employer or union plan? ☐ Yes ☐ No

If yes, name of spouse: \_\_\_\_\_

Name(s) of dependent(s): \_\_\_\_\_

3. Do you or your spouse work? ☐ Yes ☐ No

4. Some individuals may have other drug coverage, including other private insurance, Workers' Compensation, VA benefits, or State pharmaceutical assistance programs.

Will you have other **prescription** drug coverage in addition to Fallon Health? ☐ Yes ☐ No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Name of other coverage: \_\_\_\_\_

ID # for coverage: \_\_\_\_\_

5. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If "yes" please provide the following information:

Name of Institution: \_\_\_\_\_

Address & Phone Number of Institution (number and street): \_\_\_\_\_

6. Please choose a primary care physician (PCP), clinic or health center: (optional)

\_\_\_\_\_

Please check the box below if you would prefer us to send you information in another accessible format:

☐ Braille ☐ Large print ☐ Audio CD\* ☐ Data CD

\* Audio messages will not be encrypted, which means they could be intercepted by others. By selecting audio, you agree to receive these audio messages without encryption.

Please contact Fallon Health at 1-866-231-3669 (TRS 711) if you need information in an accessible format other than what is listed above. Our office hours are 8 a.m.–8 p.m., 7 days a week (April–September, Monday–Friday). TTY users should call TRS 711.

I want to get the following materials via email. Select one or more.

☐ Evidence of Coverage ☐ Formulary Email address: \_\_\_\_\_

Please read the important information on the following page and then sign below.

I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state where I live) on this application means that I have read and understand the contents of this application. If signed by an authorized individual (as described above), this signature certifies that:

1) this person is authorized under state law to complete this enrollment, and 2) documentation of this authority is available upon request by Fallon Health or by Medicare.

X \_\_\_\_\_

Your signature/authorized representative

\_\_\_\_\_  
Today's date

If you are the authorized representative, you must sign above and provide the following information:

\_\_\_\_\_  
Name (printed)

\_\_\_\_\_  
Relationship to enrollee

\_\_\_\_\_  
Address

Phone number: ( \_\_\_\_ \_\_\_\_ \_\_\_\_ ) \_\_\_\_ \_\_\_\_ \_\_\_\_ - \_\_\_\_ \_\_\_\_ \_\_\_\_

## SECTION 2 – All fields in this section are optional.

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? *Select all that apply.*

- |                                                                             |                                                                    |
|-----------------------------------------------------------------------------|--------------------------------------------------------------------|
| <input type="checkbox"/> No, not of Hispanic, Latino/a, or Spanish origin   | <input type="checkbox"/> Yes, Mexican, Mexican American, Chicano/a |
| <input type="checkbox"/> Yes, Puerto Rican                                  | <input type="checkbox"/> Yes, Cuban                                |
| <input type="checkbox"/> Yes, another Hispanic, Latino/a, or Spanish origin | <input type="checkbox"/> <b>I choose not to answer.</b>            |

What's your race? *Select all that apply.*

- |                                                           |                                                         |
|-----------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> American Indian or Alaska Native | Native Hawaiian and Pacific Islander:                   |
| Asian:                                                    | <input type="checkbox"/> Guamanian or Chamorro          |
| <input type="checkbox"/> Asian Indian                     | <input type="checkbox"/> Native Hawaiian                |
| <input type="checkbox"/> Chinese                          | <input type="checkbox"/> Samoan                         |
| <input type="checkbox"/> Filipino                         | <input type="checkbox"/> Other Pacific Islander         |
| <input type="checkbox"/> Japanese                         | <input type="checkbox"/> White                          |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> <b>I choose not to answer.</b> |

What is your gender? Select one.

- |                                     |                                                         |
|-------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Woman      | <input type="checkbox"/> I use a different term: _____  |
| <input type="checkbox"/> Man        | <input type="checkbox"/> <b>I choose not to answer.</b> |
| <input type="checkbox"/> Non-binary |                                                         |

Which of the following best represents how you think of yourself? Select one.

- |                                                                |                                                         |
|----------------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Lesbian or gay                        | <input type="checkbox"/> I use a different term: _____  |
| <input type="checkbox"/> Straight, that is, not gay or lesbian | <input type="checkbox"/> I don't know                   |
| <input type="checkbox"/> Bisexual                              | <input type="checkbox"/> <b>I choose not to answer.</b> |

## SECTION 3 – Read this important information.

### By completing this enrollment application, I agree to the following:

Fallon Health is a Medicare Advantage HMO plan with a Medicare contract. Enrollment in Fallon Health depends on contract renewal. I will need to keep my Medicare Parts A and B. (This means I must continue to pay my Medicare Part B premium.) I can only be in one Medicare Advantage Plan at a time, and I understand that my enrollment in this plan will automatically end my enrollment in another Medicare health plan. It is my responsibility to inform you of any prescription drug coverage that I have or may get in the future. I understand that if I don't have Medicare prescription drug coverage, or creditable prescription drug coverage (as good as Medicare's), I may have to pay a late enrollment penalty if I enroll in Medicare prescription drug coverage in the future. Enrollment in this plan is generally for the entire year. Once I enroll, I may leave this plan or make changes only at certain times of the year when an enrollment period is available (Example: October 15–December 7 of every year), or under certain special circumstances.

Fallon Medicare Plus Premier HMO serves a specific service area. If I move out of the area that Fallon Medicare Plus Premier HMO serves, I need to notify the plan so I can disenroll and find a new plan in my new area. Once I am a member of Fallon Medicare Plus Premier HMO, I have the right to appeal plan decisions about payment or services if I disagree. I will read the Evidence of Coverage document from Fallon Medicare Plus Premier HMO when I get it to know which rules I must follow to receive coverage with this Medicare Advantage Plan. I understand that people with Medicare aren't usually covered under Medicare while out of the country, except for limited coverage near the U.S. border.

I understand that beginning on the date Fallon Medicare Plus Premier HMO coverage begins, I must get all of my health care from Fallon Medicare Plus Premier HMO, except for emergency or urgently needed services or out-of-area dialysis services. Services authorized by Fallon Medicare Plus Premier HMO and other services contained in my plan's Evidence of Coverage document (also known as a member contract or subscriber agreement) will be covered. Without authorization, **NEITHER MEDICARE NOR FALLON MEDICARE PLUS PREMIER HMO WILL PAY FOR THE SERVICES.**

I understand that if I am receiving assistance from a sales agent, broker, or other individual employed by or contracted with Fallon Health, they may be paid based on my enrollment in Fallon Medicare Plus Premier HMO.

**Release of information:**

By joining this Medicare health plan, I acknowledge that Fallon Medicare Plus Premier HMO will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations. I also acknowledge that Fallon Medicare Plus Premier HMO will release my information, including my prescription drug event data (if applicable) to Medicare, who may release it for research and other purposes, which follow all applicable Federal statutes and regulations. The information on this form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

|                                                                                                                                                                       |                           |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------|
| For individuals helping enrollee with completing this form only:                                                                                                      |                           |
| Complete this section if you're an individual (i.e. agents, brokers, SHIP counselors, family members, or other third parties) helping an enrollee fill out this form. |                           |
| Name:                                                                                                                                                                 | Relationship to enrollee: |
| Signature:                                                                                                                                                            |                           |
| National Producer Number (Agents/Brokers only):                                                                                                                       |                           |



**1-866-231-3669 (TRS 711)**  
8 a.m.–8 p.m., 7 days a week  
(April–September, Monday–Friday)

|                                                         |  |                                         |                                                  |
|---------------------------------------------------------|--|-----------------------------------------|--------------------------------------------------|
| <b>FALLON HEALTH USE ONLY</b>                           |  | <input type="checkbox"/> New enrollment | <input type="checkbox"/> Group to group          |
| OEV required: _____                                     |  | Sales staff initials: _____             | OEV complete: _____                              |
| Name of staff member (if assisted in enrollment): _____ |  |                                         |                                                  |
| EGWP: _____                                             |  | ICEP/IEP: _____                         | AEP: _____ SEP (type): _____ Not eligible: _____ |
| Staff verification: _____                               |  | Effective date of coverage: _____       |                                                  |
| County code: _____                                      |  | Previous insurance: _____               |                                                  |
| Broker name: _____                                      |  | Broker ID: _____                        |                                                  |

# Fallon Medicare Plus<sup>™</sup> Premier HMO Summary of Benefits

January 1, 2025–December 31, 2025



# Fallon Medicare Plus Premier HMO

## 2025 Summary of Plan Benefits

This is a summary of drug and health services covered by Fallon Medicare Plus Premier HMO for January 1, 2025–December 31, 2025.

Fallon Health is an HMO plan with a Medicare contract. Enrollment in Fallon Health depends on contract renewal.

The benefit information provided is a summary of what we cover and what you pay. It doesn’t list every service that we cover or list every limitation or exclusion. To get a complete list of services we cover, please see the Evidence of Coverage, which is available online at [fallonhealth.org/medicare](https://fallonhealth.org/medicare) or by calling the phone number at the end of this book.

To join Fallon Medicare Plus Premier HMO, you and/or your spouse must be a member of an employer/ union group and you and/or your spouse must be entitled to Medicare Part A, be enrolled in Medicare Part B, and live in our service area. The service area, for the plans listed in this Summary of Benefits, includes the following counties in Massachusetts: Barnstable, Berkshire, Bristol, Essex, Franklin, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, and Worcester. Our service area also includes some cities and towns—outside of Massachusetts—that border the previously named counties. For a listing of cities and towns in our service area outside of Massachusetts, please see page 6.

Fallon Medicare Plus Premier HMO has a network of doctors, hospitals, pharmacies, and other providers. If you use providers that are not in our network, the plan will not pay for these services except in certain circumstances.

| Plan Costs                       | Monthly plan premium<br><i>You must continue to pay your Part B premium.</i>                                                                                                                                            | Medical deductible<br><i>This is the amount you must pay before your health plan pays for part of the cost of medical care and services.</i> | Maximum out-of-pocket<br><i>This is the yearly limit that you'll pay out-of-pocket for covered medical services. This amount doesn't include your monthly premium or any prescription drug costs.</i> |
|----------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Fallon Medicare Plus Premier HMO | If you pay a premium to your employer group, please contact your benefits administrator for 2025 premium information.<br><br>If you pay a premium to Fallon Health, please contact Fallon for 2025 premium information. | \$0                                                                                                                                          | \$3,400                                                                                                                                                                                               |

| Fallon Medicare Plus Premier HMO Medical Benefits                                                                                                                                                                                                                                                                                          | You pay                                                                                                                              |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------|
| <b>Inpatient Hospital Care</b><br>Includes medical, surgical, and rehabilitation services.<br><i>Requires prior authorization and Primary Care Provider (PCP) referral.</i>                                                                                                                                                                | \$250<br>per admission                                                                                                               |
| <b>Outpatient Hospital Care</b><br>Includes:<br><ul style="list-style-type: none"> <li>Outpatient surgery provided in a hospital outpatient facility and ambulatory surgical center.</li> </ul> <i>Requires prior authorization and PCP referral.</i>                                                                                      | \$125                                                                                                                                |
| <ul style="list-style-type: none"> <li>Observation services</li> </ul>                                                                                                                                                                                                                                                                     | \$0                                                                                                                                  |
| <b>Doctor Visits</b><br>Includes:<br><ul style="list-style-type: none"> <li>PCP</li> </ul>                                                                                                                                                                                                                                                 | \$15                                                                                                                                 |
| <ul style="list-style-type: none"> <li>Annual supplemental physical exam with PCP</li> </ul>                                                                                                                                                                                                                                               | \$0                                                                                                                                  |
| <ul style="list-style-type: none"> <li>Annual wellness visit with PCP</li> </ul>                                                                                                                                                                                                                                                           | \$0                                                                                                                                  |
| <ul style="list-style-type: none"> <li>Specialists</li> </ul> <i>May require referral prior authorization and PCP referral.</i>                                                                                                                                                                                                            | \$25                                                                                                                                 |
| <ul style="list-style-type: none"> <li>Telehealth services</li> </ul> <i>May require PCP referral.</i>                                                                                                                                                                                                                                     | \$0 PCP<br>\$0 Outpatient mental health<br>\$0 Outpatient substance use disorder<br>\$25 Specialists<br><i>except as noted above</i> |
| <ul style="list-style-type: none"> <li>24/7 access to doctors for non-emergency conditions by phone, mobile app, or online—with Teladoc®</li> </ul>                                                                                                                                                                                        | \$0<br>primary care services                                                                                                         |
| <b>Preventive Care</b><br>Includes Welcome to Medicare preventive visit, certain screenings, and immunizations, such as those for pneumonia and influenza, as well as other preventive care services.<br><i>May require prior authorization.</i>                                                                                           | \$0                                                                                                                                  |
| <b>Emergency Care</b><br>Copays are per visit at in- or out-of-network facilities. Coverage is worldwide. You will not pay the emergency copay if you are admitted to the hospital within 72 hours for the same condition.                                                                                                                 | \$75                                                                                                                                 |
| <b>Urgently Needed Services</b><br><ul style="list-style-type: none"> <li>In the United States and its territories</li> </ul>                                                                                                                                                                                                              | \$15                                                                                                                                 |
| <ul style="list-style-type: none"> <li>Outside of the United States and its territories</li> </ul>                                                                                                                                                                                                                                         | \$75                                                                                                                                 |
| <b>Outpatient Diagnostic Tests and Therapeutic Services and Supplies</b><br>Includes Medicare-covered lab services, diagnostic procedures and tests, X-rays, and therapeutic radiology services, as well as INR testing (anti-coagulant visit).<br><i>Some services, tests, and supplies require prior authorization and PCP referral.</i> | \$0                                                                                                                                  |
| <b>Outpatient Diagnostic Imaging</b><br>Includes Medicare-covered diagnostic radiology services such as CT scans, PET scans, MRIs, and nuclear studies.<br><i>Requires prior authorization and PCP referral.</i>                                                                                                                           | \$0                                                                                                                                  |

| Fallon Medicare Plus Premier HMO Medical Benefits                                                                                                                                                                                                                                                           | You pay                                                                                                                                |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------|
| <b>Hearing Services</b><br>Includes: <ul style="list-style-type: none"> <li>• One supplemental routine exam per year</li> </ul>                                                                                                                                                                             | \$0                                                                                                                                    |
| <ul style="list-style-type: none"> <li>• Diagnostic exams<br/>May require PCP referral.</li> </ul>                                                                                                                                                                                                          | \$25                                                                                                                                   |
| <ul style="list-style-type: none"> <li>• Hearing aid copays apply to purchases made through Amplifon, with a prescription, and vary by model and manufacturer. For coverage, purchases must be made through Amplifon.<br/><i>Limit 2 per member per year.</i></li> </ul>                                    | Copays vary from \$695 to \$2,645                                                                                                      |
| <ul style="list-style-type: none"> <li>• Hearing aids covered as part of the Benefit Bank</li> </ul>                                                                                                                                                                                                        | See Benefit Bank                                                                                                                       |
| <b>Dental Services</b><br>Includes: <ul style="list-style-type: none"> <li>• Preventive care, like exams and cleanings, through DentaQuest</li> </ul>                                                                                                                                                       | \$0                                                                                                                                    |
| <ul style="list-style-type: none"> <li>• Comprehensive non-orthodontic care, like root canals, fillings, and crowns<br/><i>May require prior authorization.</i></li> </ul>                                                                                                                                  | Copays vary from \$0-\$990                                                                                                             |
| <ul style="list-style-type: none"> <li>• Dental services covered as part of the Benefit Bank</li> </ul>                                                                                                                                                                                                     | See Benefit Bank                                                                                                                       |
| <b>Vision Care</b><br>Includes: <ul style="list-style-type: none"> <li>• One pair of Medicare-covered standard eyeglasses with standard frames or contact lenses after cataract surgery, when obtained from an EyeMed provider</li> <li>• Medicare-covered glaucoma tests</li> </ul>                        | \$0                                                                                                                                    |
| <ul style="list-style-type: none"> <li>• One supplemental routine exam per year</li> <li>• Medicare-covered exams to treat diseases and conditions of the eye</li> </ul>                                                                                                                                    | \$25                                                                                                                                   |
| <ul style="list-style-type: none"> <li>• \$150 coverage for one pair of non-Medicare-covered prescription eyeglasses or contact lenses, every year, in-network only. Excludes the one pair of Medicare-covered eyeglasses or contact lenses after cataract surgery.</li> </ul>                              | Costs above \$150                                                                                                                      |
| <ul style="list-style-type: none"> <li>• Eyewear covered as part of the Benefit Bank</li> </ul>                                                                                                                                                                                                             | See Benefit Bank                                                                                                                       |
| <b>Mental Health Care</b> <ul style="list-style-type: none"> <li>• Inpatient:<br/><i>Requires prior authorization.</i></li> </ul>                                                                                                                                                                           | \$250 per admission                                                                                                                    |
| <ul style="list-style-type: none"> <li>• Outpatient:<br/>Individual and group therapy visits<br/><i>Prior authorization is required for:</i><br/><i>Transcranial Magnetic Stimulation (TMS) Therapy</i><br/><i>Electroconvulsive Therapy (ECT)</i><br/><i>Intensive Outpatient (IOP) Therapy</i></li> </ul> | In-office without a psychiatrist: \$15<br>In-office with a psychiatrist: \$25<br>Telehealth visit, with or without a psychiatrist: \$0 |
| <b>Skilled Nursing Facility (SNF) Care</b><br><i>Requires prior authorization and PCP referral.</i> <ul style="list-style-type: none"> <li>• Per-day cost, for days 1–10 per admission</li> </ul>                                                                                                           | \$20                                                                                                                                   |
| <ul style="list-style-type: none"> <li>• Per-day cost, for days 11–100 per benefit period</li> </ul>                                                                                                                                                                                                        | \$0                                                                                                                                    |

| Fallon Medicare Plus Premier HMO Medical Benefits                                                                                                                                                                                                                      | You pay                     |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|
| <b>Outpatient Rehabilitation Services</b><br><i>Physical and occupational therapy visits beyond 60 visits each require prior authorization and PCP referral. Speech language therapy visits beyond 35 visits require prior authorization and PCP referral.</i>         | \$15                        |
| <b>Ambulance</b><br>Copays are for one-way Medicare-covered transports. Ambulance services are covered worldwide.<br><i>Non-emergency ambulance services require prior authorization.</i>                                                                              | \$0                         |
| <b>Transportation</b><br>One-way, non-emergency chair van transport from hospital to skilled nursing facility.                                                                                                                                                         | \$35                        |
| <b>Medicare Part B Prescription Drugs</b><br>Drugs that usually aren't self-administered and are injected or infused while at a doctor's office, hospital, or ambulatory/outpatient facility.<br><i>Certain drugs require prior authorization and/or step therapy.</i> | \$10–\$65                   |
| <b>Medicare Part B insulin</b>                                                                                                                                                                                                                                         | Up to \$35 per month supply |
| <b>Podiatry</b><br>Includes medically necessary foot care services.<br><i>Requires PCP referral.</i>                                                                                                                                                                   | \$15                        |
| <b>Durable Medical Equipment and Related Supplies</b><br><i>Requires prior authorization.</i>                                                                                                                                                                          | \$0                         |
| <b>Acupuncture for chronic low back pain</b><br>Includes up to 12 visits in 90 days.<br><i>Requires PCP referral.</i>                                                                                                                                                  | \$15                        |
| <b>Meals</b><br>Up to 14 fully prepared, home-delivered meals (2 meals/day for 7 days) upon discharge from an observation stay or inpatient admission at a hospital or skilled nursing facility.                                                                       | \$0                         |
| <b>Benefit Bank</b><br>Pay for dental care, prescription eyewear, fitness/gym memberships, and prescription hearing aids with your Benefit Bank card. We put money on the card, and you choose how to use it. Pay for a portion, or the full cost, of an item.         | Costs above \$250           |
| <b>Health and Wellness Programs</b>                                                                                                                                                                                                                                    |                             |
| <b>Fitness membership/classes</b><br>Fitness memberships and online fitness program services covered as part of the Benefit Bank.                                                                                                                                      | See Benefit Bank            |
| <b>WW® (Weight Watchers)</b><br>WW® online memberships covered as part of the Benefit Bank.                                                                                                                                                                            | See Benefit Bank            |
| <b>Care Connect</b><br>24/7 phone access to registered nurses who will recommend where you should receive care or will connect you to your doctor.                                                                                                                     | \$0                         |

# Part D Prescription Drug Benefits

These medications are ones that you need a prescription to receive, and that you typically get at a retail pharmacy or through mail order. There are 3 “drug payment stages” for Part D prescription drug coverage: deductible stage, initial coverage stage, and catastrophic coverage stage.

Our plan covers most Part D vaccines at no cost to you in all coverage stages. You’ll pay no more than \$35 for a 30-day supply of covered insulin drugs, regardless of the drug coverage stage.

## Deductible Stage

Because there is no deductible for Fallon Medicare Plus Premier HMO, this stage doesn’t apply to your Part D prescription drug coverage.

## Initial Coverage Stage

You pay the following amounts until your yearly out-of-pocket drug costs (your payments or those paid on your behalf) total \$2,000.

| Fallon Medicare Plus Premier HMO          |               |                             |                             |               |                             |                             |
|-------------------------------------------|---------------|-----------------------------|-----------------------------|---------------|-----------------------------|-----------------------------|
|                                           | Retail        |                             |                             | Mail order    |                             |                             |
|                                           | 30-day supply | 60-day supply               | Tier 1:<br>100-day supply   | 30-day supply | 60-day supply               | Tier 1:<br>100-day supply   |
|                                           |               |                             | Tiers 2-4:<br>90-day supply |               |                             | Tiers 2-4:<br>90-day supply |
| <b>Tier 1:</b><br>Preferred generic drugs | \$0           | \$0                         | \$0                         | \$0           | \$0                         | \$0                         |
| <b>Tier 2:</b><br>Generic drugs           | \$10          | \$20                        | \$30                        | \$10          | \$20                        | \$20                        |
| <b>Tier 3:</b><br>Preferred brand drugs   | \$30          | \$60                        | \$90                        | \$30          | \$60                        | \$60                        |
| <b>Tier 4:</b><br>Non-preferred drugs     | \$65          | \$130                       | \$195                       | \$65          | \$130                       | \$162.50                    |
| <b>Tier 5:</b><br>Specialty drugs         | \$65          | Not available for this tier | Not available for this tier | \$65          | Not available for this tier | Not available for this tier |
| <b>Tier 6:</b><br>Select care drugs       | \$0           | Not available for this tier | Not available for this tier | \$0           | Not available for this tier | Not available for this tier |

Certain drugs are not available in an extended-day supply. These drugs may be included within Tiers 1-6. Your copays for insulin drugs are no more than: \$35 for a 30-day supply purchased at retail or through mail order; \$105 for a 90-day supply purchased at retail, and \$70 for a 90-day supply purchased through mail order.

## Catastrophic Coverage Stage

After your yearly out-of-pocket drug costs reach \$2,000, you pay \$0 for all covered prescription drugs.

For more information about cost-sharing specific to the different phases of the benefit, please use the contact information included on the back page to call us.

# Fallon Medicare Plus Premier HMO service area

(ZIP codes listed represent the service area outside of Massachusetts)

| MASSACHUSETTS       |                   |                    |                    |
|---------------------|-------------------|--------------------|--------------------|
| Barnstable County** | Essex County**    | Hampshire County** | Plymouth County**  |
| Berkshire County**  | Franklin County** | Middlesex County** | Suffolk County**   |
| Bristol County**    | Hampden County**  | Norfolk County**   | Worcester County** |

| CONNECTICUT             |                         |
|-------------------------|-------------------------|
| Town                    | ZIP                     |
| <b>Hartford County*</b> |                         |
| East Granby             | 06026                   |
| East Windsor            | 06088                   |
| East Windsor Hill       | 06028                   |
| Enfield                 | 06082<br>06083          |
| Granby                  | 06035<br>06090          |
| Hazardville             | 06082                   |
| North Granby            | 06060                   |
| N. Thompsonville        | 06082                   |
| Scitico                 | 06082                   |
| Suffield                | 06078<br>06080<br>06093 |
| Thompsonville           | 06082                   |
| West Granby             | 06090                   |
| West Suffield           | 06093                   |
| Windsor Locks           | 06096                   |
| <b>Tolland County*</b>  |                         |
| Ellington               | 06029                   |
| Somers                  | 06071                   |
| Stafford                | 06075                   |
| Stafford Springs        | 06076                   |
| Union                   | 06076                   |
| Willington              | 06279                   |
| <b>Windham County*</b>  |                         |
| Ashford                 | 06278                   |
| Ballouville             | 06233                   |
| Danielson               | 06239                   |
| Dayville                | 06241                   |
| East Killingly          | 06243                   |

| CONNECTICUT, cont.          |                                           |
|-----------------------------|-------------------------------------------|
| East Woodstock              | 06244                                     |
| Eastford                    | 06242                                     |
| Fabyan                      | 06256                                     |
| Killingly                   | 06233<br>06239<br>06241<br>06243<br>06263 |
| Mechanicsville              | 06277                                     |
| North Grosvenordale         | 06255                                     |
| North Windham               | 06256                                     |
| Pomfret                     | 06258                                     |
| Pomfret Center              | 06259                                     |
| Putnam                      | 06260                                     |
| Rogers                      | 06263                                     |
| South Woodstock             | 06267                                     |
| Thompson                    | 06277                                     |
| Woodstock                   | 06281                                     |
| Woodstock Valley            | 06282                                     |
| NEW HAMPSHIRE               |                                           |
| Town                        | ZIP                                       |
| <b>Cheshire County*</b>     |                                           |
| Fitzwilliam                 | 03447                                     |
| Rindge                      | 03461                                     |
| <b>Hillsborough County*</b> |                                           |
| Brookline                   | 03033                                     |
| Greenville                  | 03048                                     |
| Hollis                      | 03049                                     |
| Hudson                      | 03051                                     |
| Jaffrey                     | 03452                                     |
| Mason                       | 03048                                     |

| NEW HAMPSHIRE, cont.      |                                           |
|---------------------------|-------------------------------------------|
| Nashua                    | 03060<br>03061<br>03062<br>03063<br>03064 |
| New Ipswich               | 03071                                     |
| Pelham                    | 03076                                     |
| <b>Rockingham County*</b> |                                           |
| Atkinson                  | 03811                                     |
| East Kingston             | 03827                                     |
| Hampstead                 | 03841                                     |
| Hampton                   | 03842                                     |
| Hampton Beach             | 03843                                     |
| Hampton Falls             | 03844                                     |
| Plaistow                  | 03865                                     |
| Salem                     | 03079                                     |
| Seabrook                  | 03874                                     |
| South Hampton             | 03827                                     |
| Windham                   | 03087                                     |
| NEW YORK                  |                                           |
| Town                      | ZIP                                       |
| <b>Columbia County*</b>   |                                           |
| Austerlitz                | 12017                                     |
| Canaan                    | 12029                                     |
| Chatham                   | 12037                                     |
| Chatham Center            | 12184                                     |
| Copake                    | 12516                                     |
| Copake Falls              | 12517                                     |
| Craryville                | 12521                                     |
| East Chatham              | 12060                                     |
| Hillsdale                 | 12529                                     |
| Malden Bridge             | 12115                                     |
| New Lebanon               | 12125                                     |

| NEW YORK, cont.           |                                  |
|---------------------------|----------------------------------|
| Old Chatham               | 12136                            |
| West Lebanon              | 12195                            |
| <b>Rensselaer County*</b> |                                  |
| Berlin                    | 12022                            |
| Stephentown               | 12168<br>12169                   |
| RHODE ISLAND              |                                  |
| Town                      | ZIP                              |
| <b>Bristol County*</b>    |                                  |
| Bristol                   | 02809                            |
| Warren                    | 02885                            |
| <b>Newport County*</b>    |                                  |
| Little Compton            | 02837                            |
| Tiverton                  | 02878                            |
| <b>Providence County*</b> |                                  |
| Burrillville              | 02826<br>02830<br>02839<br>02858 |
| Cumberland                | 02864                            |
| Glendale                  | 02826                            |
| Harrisville               | 02830                            |
| Mapleville                | 02839                            |
| North Smithfield          | 02824<br>02876<br>02896          |
| Oakland                   | 02858                            |
| Pawtucket                 | 02860<br>02861<br>02862          |
| Slatersville              | 02876                            |
| Smithfield                | 02917                            |
| Valley Falls              | 02864                            |
| Woonsocket                | 02895                            |

\* Partial County

\*\* Full County

# More information

To learn more about Fallon Medicare Plus Premier HMO or to view plan documents, visit our webpages or call us using the information listed below.

|                                                                       |                                                                                                                                                                                                                                            |
|-----------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Fallon Medicare Plus Premier HMO</b>                               | Current members: <b>1-800-325-5669 (TRS 711)</b><br>Prospective members: <b>1-866-231-3669 (TRS 711)</b><br>Website: <b>fallonhealth.org/medicare</b><br>Hours: 8 a.m.–8 p.m., Monday–Friday<br>(7 days a week, Oct. 1–March 31)           |
| <b>Provider Directory</b>                                             | fallonhealth.org/findphysician                                                                                                                                                                                                             |
| <b>Pharmacy Directory</b>                                             | fallonhealth.org/pharmacyfinder                                                                                                                                                                                                            |
| <b>Prescription Drug Formulary</b>                                    | fallonhealth.org/medicare-formulary                                                                                                                                                                                                        |
| <b>Original Medicare</b><br>More information about coverage and costs | "Medicare & You" handbook<br>• View online: <a href="http://www.medicare.gov">http://www.medicare.gov</a><br>• Get a copy: Call 1-800-MEDICARE (1-800-633-4227)<br>24 hours a day, 7 days a week.<br>TTY users should call 1-877-486-2048. |

This document is available in other formats such as braille, large print, audio CD, or data CD.



*Fallon Health and Amplifon Hearing Health Care are independent, unaffiliated companies. Hearing services are administered by Amplifon Hearing Health Care, Corp. Teladoc Health, Inc. All rights reserved. WeightWatchers logo and WeightWatchers are the trademarks of WW International, Inc. ©2023 WW International, Inc. All rights reserved.*

## IMPORTANT INFORMATION:

### 2025 Medicare Star Ratings

Official U.S.  
Government  
Medicare  
Information



#### Fallon Health - H9001

For 2025, Fallon Health - H9001 received the following Star Ratings from Medicare:

**Overall Star Rating:** ★★★★★☆

**Health Services Rating:** ★★★★★☆

**Drug Services Rating:** ★★★★★☆

Every year, Medicare evaluates plans based on a 5-star rating system.

#### Why Star Ratings Are Important

Medicare rates plans on their health and drug services.

This lets you easily compare plans based on quality and performance.

Star Ratings are based on factors that include:

- Feedback from members about the plan's service and care
- The number of members who left or stayed with the plan
- The number of complaints Medicare got about the plan
- Data from doctors and hospitals that work with the plan

The number of stars show how well a plan performs.

- ★★★★★ EXCELLENT
- ★★★★☆ ABOVE AVERAGE
- ★★★☆☆ AVERAGE
- ★★☆☆☆ BELOW AVERAGE
- ★☆☆☆☆ POOR

More stars mean a better plan – for example, members may get better care and better, faster customer service.

Get More Information on Star Ratings Online

Compare Star Ratings for this and other plans online at [Medicare.gov/plan-compare](https://www.medicare.gov/plan-compare).

Questions about this plan?

Contact Fallon Health 7 days a week from 8:00 a.m. to 8:00 p.m. Eastern time at 888-377-1980 (toll-free) or 711 (TTY), from October 1 to March 31. Our hours of operation from April 1 to September 30 are Monday through Friday from 8:00 a.m. to 8:00 p.m. Eastern time. Current members please call 800-325-5669 (toll-free) or 711 (TTY).



**[fallonhealth.org/medicare](https://fallonhealth.org/medicare)**

**1-866-231-3669 (TRS 711)**

8 a.m.–8 p.m., 7 days a week.

(April–September, Monday–Friday)

---

*Fallon Health is an HMO plan with a Medicare contract. Enrollment in Fallon Health depends on contract renewal.  
Teladoc Health Inc. All rights reserved. Fallon Health and Amplifon Hearing Health Care are independent, unaffiliated companies.  
Hearing services are administered by Amplifon Hearing Health Care, Corp.*